

# CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND  
MEDICAL MALPRACTICE DIVISION  
311 W. WASHINGTON ST. STE.300  
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	<input type="checkbox"/>	\$ _____	_____
Return Surcharge	<input type="checkbox"/>	\$ _____	_____
Additional Surcharge	<input type="checkbox"/>	\$ _____	_____
Surcharge Change Reason: _____			

Health Care Provider:						Medical License No. (Individual):							
						EIN# (Entity): Please do not provide individual social security number							
Address (Street, City, State, Zip):						County of Service:							
Policy No.:						Occurrence Claims Made Reporting Endors.		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Retro Date (CM or RP )		Including employees <input type="checkbox"/>  Excluding employees <input type="checkbox"/>	
Coverage Dates: From: _____ To: _____						ISO Code:				Date Surcharge Rec'd from Provider:			
Limits of Liability: \$_____ per \$_____ annual occurrence aggregate						Premium: (IN P/L Only)		Surcharge:		Under 90 day Penalty:		Over 90 Day Penalty:	
<b>The following credits are only available for health care providers identified under Rule 60:</b>													
Credits: (Only one credit may be applied)		Part-Time Credits <input type="checkbox"/> 0-12 hrs. 75% <input type="checkbox"/> 13-24 hrs. 50% <input type="checkbox"/> 25-30 hrs 25%		Medical School Faculty <input type="checkbox"/> 67%  <input type="checkbox"/> Retired		Newly Licensed Physicians <input type="checkbox"/> 1 <sup>st</sup> yr. 50% <input type="checkbox"/> 2 <sup>nd</sup> yr. 25%		Fellowship <input type="checkbox"/> Full-Time 50% <b>Greater of:</b> <input type="checkbox"/> Full-time surcharge for medical practice outside fellowship <input type="checkbox"/> 50% of surcharge due for specialty class of fellowship					
Insurance Carrier Name:												NAIC#	
Contact Name:								Telephone Number/Email:					
<p>The undersigned Insurance Company/Broker, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand (\$250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand (\$750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.</p> <p>It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital or nursing home, or is One Hundred and Ten Percent (110%) of the premium for non-physician, non-hospital or non-nursing home providers. Said Company/Broker also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred (\$100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within <b>thirty (30) days of receipt but not more than sixty (60) days from the effective date of said policy.</b></p> <p>It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.</p>													
Dated this ____ day of _____, 20__ at the insurance office of _____													
Signed by: _____ Authorized Signature													
Printed: _____													
Title: _____													